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ABSTRACT

This issue of "Special Parent/Special Child" describes the role of occupational and physical therapy in maximizing the potential of special needs children. Physical and occupational therapy are defined and the training and functions of therapists in each area are outlined. Also discussed are the goals of therapy programs in developing gross and fine motor skills, assessment methods, types of therapeutic exercises, the functions of the school-based physical or occupational therapist, and the parents' role as co-therapists. The issue concludes with a column addressing the problem of psychological depression experienced by parents of special needs children. (JDD)

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Special Parent ★Special Child

Practical pointers for parenting handicapped children

VOL. 4, NO. 6

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NOVEMBER/DECEMBER 1988

SPECIAL HELP: PHYSICAL AND OCCUPATIONAL THERAPY

Special children often require the intervention of occupational and physical therapists in order to maximize their potential. Youngsters with medically disabling conditions such as cerebral palsy, muscular dystrophy, spina bifida, brain injury or birth trauma benefit from the kinds of specialized help offered by skilled physical and occupational therapists.

However, there are also many special children with more subtle difficulties such as learning disabilities or developmental delays which subsequently can interfere with their ability to coordinate hand-eye and other muscles of the body. Youngsters who exhibit these kinds of problems often need assistance, for example, with gait, balance, walking without stumbling, reaching and grasping. The ability to engage in these and similar activities is important for the child to be able to move freely, run, jump, play like others, feed, dress and later achieve in school-related tasks such as reading and writing. Parents and teachers of special children are often unclear as to why, how and for what purpose occupational and physical therapies are indicated.

In this issue we will focus on the role of these special therapies, how they help and how best parents and schools can participate.

What is physical therapy?

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Physical therapy, commonly known as PT, focuses on helping individuals strengthen, improve or develop their **gross motor skills**. This includes coordinating the large muscles of the body for walking, kneeling, crawling, running, hopping, balancing on one foot, moving or rolling from side to side, going from a sitting to standing position and the reverse. Helping with posture, gait and body awareness such as knowledge of body parts and sidedness is also part of physical therapy. **The physical therapist** is a trained professional who is a graduate of a specialized course of training. Most states have individual licensing and certification regulations which accompany the formal course of study. The therapist follows a doctor's recommendation when designing an individualized program that will remediate specific weak-

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nesses. For example, a child's arm or shoulder muscles might be weakened by birth trauma, illness or accident and need to be strengthened before he can use crutches.

One of the key functions of the physical therapist is to train the physically disabled child in the best way to use adaptive devices, i. e. wheelchairs, walkers, braces, splints or prosthetic devices so that the disabled child is kept as mobile as possible.

The physical therapy program

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Suzanne Della Corte, M.S., for 15 Years co-director of the school, is responsible for curricula, staff development and supervision. She is author of numerous research projects in the field and has edited psychology textbooks for a leading New York publisher.

The goal of any physical therapy program is to increase muscle strength, mobility of limbs and joints and to improve the overall endurance of the disabled child. The physical therapist often focuses on increasing the disabled child's **range of motion** and has specific strategies to help, for example, the child move upper trunk, rotate arms and shoulders, extend arms in and out or up and down. Range of motion exercises can also include proper rotation of hips, knees, ankles.

Often the therapist has specific exercises that will ease tight muscles or relax drawn-up limbs. Not only does the physical therapist seek to improve the walking and gait of the ambulatory child, he also regulates the body position of the wheelchair bound child to promote comfort, prevent skin breakdowns and maximize functioning. The physical therapist checks constantly to see that braces fit properly, crutches are at proper height, the wheelchair is properly sized.

The first part of the physical therapy program is a careful assessment of how the child moves and coordinates body parts. **Observations** of the child's **posture** while sitting on the floor, in a chair and standing upright are made. The therapist will check the youngster's trunk and spine for an abnormal curvature called **scoliosis**. Legs are checked to see if both are even or if the child has any other bone deformity that might interfere with walking or running or balance. The therapist will note if the child toes in or out as he walks, how he moves from a sitting to standing position and how the youngster maneuvers steps, climbs stairs, opens and closes doors.

Muscles and muscle tone will be examined for spasticity (tightening of muscles and joints) or, on the other hand, for any weakness or floppiness.

Often the therapist will watch the child in play situations so that he can assess if the youngster is able to coordinate arms and legs to move, run, catch or throw a ball with adequate dexterity.

The wheelchair bound child's assessment focuses on transfers: wheelchair to floor, floor to wheelchair, wheelchair to standing and reverse, wheelchair to classroom chair and back, wheelchair to toilet and reverse.

During the evaluation the phsycial therapist will discover at which point in the sequence of

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events the child is experiencing difficulty. At that point the activity wil be broken down step-by-step and a **series of therapeutic exercises or devices** will be designed to help the child surmount the problem area. For example:

- a series of exercises and games to help strengthen specific muscles that will compensate for weakened body parts.
- rotational exercises or changing body positions might be used for relaxation.
- stretching and elongating limbs might be used to release tightened muscles.
- using devices such as a splint or foot brace, for example, to ease tight calf muscles that are causing a "tippy toe" walk. This could be coupled with flexing the child's heel to relax the muscles and a verbal reminder of "heels down" might be used as the child walks.
- devices such as rails, supports and visual clues such as painting stair treads different colors to aid in stair climbing.

Other interventions such as therapeutic massages, electro therapy, including ultrasound, hot packs and water therapy are usually found in hospital settings and are most often prescribed for acute tightness problems and other medical reasons, for example, skin breakdowns.

Throughout the physical therapy program the child is reviewed constantly to make sure muscles are not tightening up, that devices, when worn, are not causing friction and skin breakdowns and, above all, that **the child is maintaining whatever abilities he has.**

A good physical therapy program helps children move as independently as possible thus promoting self-reliance and self-esteem.

Physical therapy and the schools

When it is determined that the child's physical disability in some way interferes with academic performances, the school must, according to federal law, provide physical therapy sessions. These are often scheduled during the child's school day. The physical therapist who is school-based can provide not only individualized therapy for the disabled child but consultative services to the school as well. The therapist can recommend how and when to use special equipment that will benefit the disabled child's school performance. This can be as simple as making sure that the child's school desk and chair are the proper size and height so that he is not pitched too far forward or that his feet are placed on the floor. Proper positioning of the wheelchair bound child so that he is better able to position head and shoulders for writing or board work is another example.

The physical therapist might also consult with the gym teacher and perhaps make recommendations on how to translate useful exercises into games and play. Often the physical therapist can provide suggestions on ways to increase mainstreaming opportunities, such as making the school accessible with ramps.

The school-based therapist can provide an invaluable service if he is able to arrange **in-service programs** for classroom teachers.

Answering questions about the child's disability can allay many fears and misconceptions. Providing guidance on proper handling of equipment can make the school day much easier for both the dis-

abled child and his teacher.

Teachers and other school personnel who have received appropriate instruction tend to have a greater aceptance of the phsycially disabled child in their midst. If the teacher's welcome is genuine, chances are the children in the class will follow suit. Creating this kind of positive atmosphere enhances the likelihood of the disabled child's success at school.

Physical therapy and the home

With proper guidance and instruction, parents can often carry through at home specific exercises and activities that will reinforce the therapy sessions the child receives elsewhere. Many physical therapy activities can be integrated into the home. For example, games and toys can motivate the child to go through range-of-motion exercises. Parents and other family members should understand that sometimes the exercises are tedious or even uncomfortable although this is to be avoided if possible. The disabled youngster will require much understanding and frequent encouragement in order to continue. Parents can help by getting the message across to their child that the therapy is important and, while acknowledging the difficulty, they should not be tempted to give in or skip sessions.

Parents and therapist should have frequent contact; in this way parents can become co-therapists.

What is occupational therapy?

Originally, occupational therapy focused on retraining individuals who had sustained wartime injuries or accidents and needed special rehabilitation of their hands to become independent and employable—hence the name occupational therapy or OT, as it is commonly known.

Gradually, the field extended itself to the treatment of the small muscles of the body, concentrating primarily on facial muscles and muscles found in the upper trunk, arms and hands. In disabled children the OT specialist focuses on helping the child with proper chewing, swallowing, placement of tongue and mouth for speech formation. Another concern is if the child has the manual dexterity necessary to engage in activities of daily living such as feeding, dressing, toileting and if hand-eye coordination is adequate for writing or copying.

The occupational therapist is a trained, licensed specialist who has pursued a formal course of study. An important part of such training includes how to design splints, arm and wrist devices and other adaptive equipment which aid the special child in manipulating everday objects—lifting a cup, raising a spoon, handling a toothbrush, crayons or pencil. In the older child the OT specialist helps with homemaking and prevocational activities.

The occupational therapy program

WORDS TO KNOW

Tactile: sense of touch, ability to discriminate hard, soft, cold, hot, sharp, dull and to respond appropriately in threatening situations.

Visual: sight and perception of visual stimuli includes ability to see and perceive depth, near and far, the main figure in a busy picture, for example.

Auditory processing: being able to interpret directions, sounds, etc. and to respond appropriately with motor/physical actions.

Oral-motor control: includes tongue control, lip closure, jaw control, swallowing; being able to drink from a cup with good lip closure or tolerating all food textures with good chewing/swallowing.

Daily living skills: dressing, feeding, hygiene, grooming and other abilities necessary to be independent in school and home situations.

Courtesy of Paula Raskin, OTR

The occupational therapy program focuses on strengthening and developing the individual's **fine motor skills**. This includes coordinating the small muscles of hands and arms so that the individual is able to reach, grasp, hold or let go. Children with impaired or delayed fine motor development experience much frustration in learning how to dress, undress, tie shoes, cut food, open containers, use a straw. School age children with this type of dysfunction experience difficulty manipulating pen or pencil correctly for handwriting. If muscles of arms and hands are not coordinated with eye movements, the child often finds copying from the blackboard difficult. The occupational therapist is also on the lookout for other manifestations of perceptional problems such as tracking eyes in proper left-to-right sequence, finding the right place on the page, sensing if things are near or far, duplicating a pattern, spotting a missing element when shown a picture.

Many learning disabled children or children with neurological dysfunctions display these and other similar problems which can interfere with school performance.

After observing and evaluating the child, the OT specialist designs a step-by-step program to remediate any weakness. For example:

- specific exercises for floppy or tight arm and shoulder muscles.
- using finger puppets or play dough to strengthen the muscles in fingers, wrists and hands.
- bouncing on a large therapy ball to increase attention span.
- having the child complete dot-to-dot pictures, move through mazes, work puzzles, copy patterns and block designs which will aid hand-eye coordination and perception.
- practicing dressing and undressing routines by breaking the activity into small sequential steps.
- "wheelbarrow walking" or walking on hands while the therapist holds onto the child's legs so that the youngster can feel pressure on his joints.

Sensory motor integration is a special type of occupational therapy which focuses on how accurately children take in information through their senses. Many special children have problems organizing the information that is relayed to them through their sense of sight, sound, touch or feel and translating that information into purposeful activities. Such children are distractible, unable to screen out everyday ordinary sights and sounds.

Some afflicted youngsters are oversensitive to the pressure of their clothes on their bodies or are overly annoyed by others touching them or coming close to them. Often these children have problems locating their body parts because they are not accurately sensing pressure normally felt through their joints and muscles.

Some children might have an impaired sense of gravity especially as it relates to head and inner ear functioning and thus have difficulty swinging, balancing, moving along a straight line or in a circle. Paradoxically, some special children crave this form of stimulation. Some researchers are investigating whether this type of imbalance is the reason why some special children rock or spin excessively.

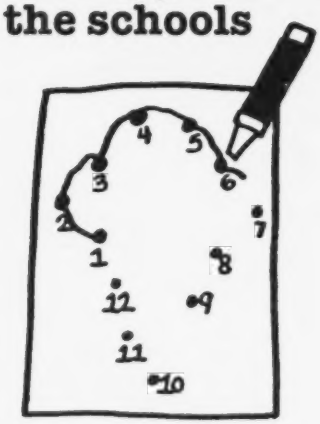
Many youngsters who exhibit sensory problems also have trouble with **motor planning**. They are unable to automatically move from one place to another, especially in unfamiliar surround-

ings, are fearful of environmental changes such as differences in ground surfaces. They may even have difficulty in sequencing simple motor activities such as taking off boots before attempting to take off trousers.

The sensory motor specialist is trained in designing specific programs to help the child organize sensory information. For example:

- rubbing lotion on the child's body parts to help him sense their location.
- having the child propel himself face down on a scooter board to help him feel pressure on his joints.
- having him participate in a variety of imitation games, obstacle courses, movement games, where he will translate verbal directions into activities.

Occupational therapy and the schools



If it is determined that a child's fine motor coordination problems are interfering with school peformance, then it is mandated that the child receive occupational therapy services.

In many cases the child's teacher is the primary informant. The OT specialist and classroom teacher should have frequent contact because so many OT activities focus on pre-reading and pre-writing skills.

Often the OT specialist works with the physical therapist to coordinate and reinforce range of motion exercises especially when the child receives PT as well as OT services. The speech pathologist and the OT specialist often work together designing facial muscle exercises to enhance speech formation.

In addition to consulting with school personnel, the OT can also recommend safety features such as hand rails or other adaptive devices such as toilet bars which will promote effective functioning for the disabled child.

The OT and the home

Many of the activities used by occupational therapists can be duplicated at home without undue effort. Puzzles, puppet play, blocks, play dough, arts and crafts activities, playing catch, obstacle courses are all good examples.

Some OT specialists suggest playing video games as a fun way to improve hand-eye coordination.

It's best to check with the child's therapist before undertaking **any** home program. It is also extremely important to find out length of time and duration of any activity.

Do's and don'ts

Do ask for help. Don't struggle needlessly with your child on activities of daily living—feeding, dressing, etc. Perhaps there are some specific techniques you can be shown that will help. Unless you let the therapists know of your difficulties they wil assume all is well.

Do ask for clarification of anything you don't understand. OT and PT specialists have their own professional jargon and often the terminology used is difficult to understand or confusing to the layperson. Don't be embarrassed. Ask for concrete examples until

things are meaningful.

Do alert the therapist working with your child of any changes, regressions, stiffness, behavioral differences. These need to be checked by appropriate professionals.

Don't overdo therapy sessions at home with your special child, pushing him to the limits of endurance. This will only serve to frustrate him and may do more harm than good.

Do become aware that most therapeutic intervention prevents the child from losing ground. Often, improvement is imperceptible and unless parental expectations are realistic, both parent and child can easily become frustrated.

Do become an informed parent. Reading about your child's disability or joining a group will help you plan activities that are geared to your child's level of functioning. Knowing about the course of your youngster's disability can help you allay his and your anxiety.

Do let therapists know of your willingness to help. A properly planned home program can reinforce therapy sessions.

Don't convey anxious feelings or disappointment to your child. He needs your encouragement and your compliments in order for him to keep on trying. Recognize your child's struggles with praise and rewards.

Do find parents and children with similar disabilities—share ideas, experiences, babysitting. This will make you and your child feel less alone.

The reader asks

Q. My child has been referred by the school for an occupational therapy evaluation. Should I take him to the doctor or hospital?

A. The editors have asked Paula Raskin, an OTR of Mt. Kisco, NY, to respond.

"OTs working with school age children are called in if the child is experiencing difficulty in acquiring daily living skills or coordinating hand-eye and other muscles or is having trouble translating hearing, seeing, touching information so that he is able to follow directions, read, write and behave as others his age. The evaluation may consist of record reviews, classroom observation, parent/teacher reports and one or more sessions for more formal testing. From these findings a treatment plan can be developed.

If the child is identified as having an OT problem that interferes in his academic development, the school district is legally mandated by federal laws in special education to provide an adequate OT program for that child. Some school districts have an OT on the staff of related professionals or may contract to an outside therapy provider on a case by case need. If the child is identified with problems but these problems DO NOT interfere with his academic functioning in the classroom, the school system is not obligated to provide the OT service as a part of the program. In this case, it is no longer an educational issue and it is considered to be more of a medical issue. Some districts require that a child be enrolled in special education before providing any services. A doctor's prescription may also be mandatory by the school. In the case where the child is in need of service and it is not provided through the school

district for the above reasons, it's a good idea for the parents to seek OT through a private, adequately trained clinician. In many situations, under medical supervision, this service is generally covered by medical insurance. You will need to check with your insurance provider to see about reimbursement. You can obtain the names of OTs in private practice through the local hospitals, local or state OT associations or other related professionals. They will have more information on each state's requirements of occupational therapy services."

PSYCHOLOGIST'S CORNER:

Coping with depression

by George Popper, Ph. D.

The bills have to be paid and there's not enough money. The promotion you hoped for went to another person Someone close to you has died. The child you wanted so very much has turned out to be less than perfect.

From time to time, all of us have experienced the pain of depressionalthough few of us really understand what it is. Most people think of depression in terms of sadness or a loss of enthusiasm, however, depression is a more complicated reaction. When we are truly depressed the only thing we really want to do is pull the covers over our heads and sleep. Making even the simplest decision is a painful chore. A tremendous effort is required to go to work or even to participate in activities we usually enjoy. It's as if all color left the world and we were surrounded by a gray emptiness—no love, no joy, no hate, nothing. Given time and the support of people who care about us, most of us can overcome feelings of depression. On occasion, psychotherapy or possibly medication is needed if the depression is severe or persistent.

Evidence suggests there is a genetic predisposition for depression. There are also physiological factors associated with certain types of depression and research has shown the way to new diagnostic tools and treatments. From a psychological perspective, depression can be thought of as anger turned inward. To a large extent, most depressed people are angry with themselves. Whatever event caused them to feel depressed also reinforced some negative aspect of their self-image. For example, there are parents who become profoundly disappointed when their child is born with problems. The disappointment becomes shame, the shame turns into hidden anger, the anger reinforces a concept that you're not a very good parent and that feeling is experienced as depression. When you look at it on paper, the whole process seems irrational and, in fact, it often is.

The treatment of depression almost always entails learning how to cope with those situations that engendered the feeling in the first place. It is true that there are drugs that can make a person feel much less depressed and they are sometimes an important part of the therapy. More important is the development of a sense of competence to deal more effectively with life's stresses and with anger.

Special parents should explore ways of coping with their feelings by joining a parent group, sharing ideas, feelings and ways of solving problems. The more we know, the better able we are to handle feelings of stress and depression.

Illustrations by Leah Spring